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ABSTRACT

Although group psychotherapy is the preferred method of treatment for short-term hospitalized clients, empirical evidence of the efficacy of such a treatment method is lacking. To examine the major themes expressed in an inpatient group over time, as well as to evaluate the methodology for selecting and implementing group psychotherapy, a total of 34 hospitalized patients participated in an eight member group over a 3-month period. The group met for 1 hour per day, 3 days per week. Daily process notes were taken and analyzed for recurrent themes. The results showed the existence of 60 major themes that could be grouped into six basic categories: boundary and limit setting, reflected in rule setting and emphasis on group integrity; group composition, emphasizing the stability and continuity of the group; group cohesion; group problem-solving; generalization of group activities to adaptive functioning in the outside world; and control of affective states. The issue of voluntary participation in the groups and the discussion of voluntary status during the screening process were found to be unecessary; both were subsequently eliminated. (BL)

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Major Themes in Brief Inpatient Group Psychotherapy

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Major Themes in Brief Inpatient Group Psychotherapy

There has been a dramatic decrease in the number of inpatient hospital days in the period from 1969 through 1978, most of which was accounted for by a decrease in psychiatric days (Kiesler & Sibulkan, 1983). These short-term psychotherapeutic interventions have become a necessity in inpatient settings. Whereas brief interventions have been used for many years, they have only recently gained full acceptance in the field (Imber, Lewis, & Loiselle, 1979).

One of the most interesting forms of short-term inpatient psychotherapy is group psychotherapy. Although this modality has been practiced for over sixty years and in hospitals for about forty years (Kibel, 1981), much research needs to be done to clarify its definition and usefulness. Group inpatient psychotherapy is interesting because of its unique characteristics. The client participants tend to be a heterogeneous lot yet each shares the circumstance of major disruption in their lives (Erickson, 1981). Individual sessions tend to take on new characteristics because the groups are forever beginning, with some clients terminating and others entering (Rice & Rutan, 1981).

Unfortunately, empirical evidence on the efficacy of group psychotherapy in a short-stay setting is lacking. Erickson (1983) likens current principles and practices as "a catch-all drawer filled with...memorabilia of some exciting years of clinical practice badly in need of sorting " (p.138).

The purpose of this paper is to do some sorting by examining the major themes expressed in an inpatient group over time as they relate to the therapeutic goals of inpatient groups cited in the literature. Also, we evaluate the methodology for selecting and implementing group psychotherapy. Some of the most frequently mentioned goals of group psychotherapy in short-term, short-stay settings are boundary maintenance, instilling hope, social sharing of feelings and attitudes, and reducing target symptoms (Maxmen, 1978; Erickson, 1981: Erickson, 1982).

The methodology we chose is similar to that described by Maxmen in his educative model of group psychotherapy: focusing on the here and now, establishing a screening process, facilitating the perception that clients rather than therapists are primary therapeutic agents, and teaching clients how to "behave therapeutically" as the primary goal of the group. The latter concept is defined as attending to those actions and feelings that resulted in and sustains hospitalization.

METHOD

The inpatient group maintained a fluid census of up to eight members representing varied diagnostic categories. Major affective disorders and personality disorders were most frequent. Two co-therapists, one a Ph.D. pyschologist and the other a clinical psychology intern, facilitated the group. They structured the group by focusing on patient-to-patient interaction, relating the past and future to the present, and examining extra-group behavior in relation to intra-group behavior. Process notes were recorded by a silent observer, either a psychiatric nurse or medical student. Requisites for group membership included regular, prompt attendance, within-group confidentiality, and abstinence from disruptive or abusive behavior. Potential members were briefed regarding group procedure and policy, and informed of their option to join or discontinue participation at any time.

The group met for one hour, three days per week, on a continuous basis. Median group attendance per member was five sessions. Total number of group members during this three-month period was 34. Daily process notes were reviewed for thirty-seven sessions over a three-month period in order to derive

major recurrent themes addressed by the group. Inter-rater reliability was evaluated for frequency of theme and category fit by two clinical psychology interns with past experience in facilitating the inpatient group.

RESULTS

Sixty major themes were distilled from the process notes which were further classified into six basic categories. The first category, boundary and limit-setting issues, was reflected in rule setting and emphasis on group integrity. For example, the group developed rules governing attendance requirements, tardiness and smoking restrictions, and procedures for spontaneously terminating membership. Regard for group boundaries was expressed by insistence on confidentiality and freedom from external intrusions and distractions of staff members, other patients and environmental noise, (TV, radio, or loud talking.)

The second category of themes, group composition, suggests the strong importance of stability and continuity of the group. Welcoming new or returning members and separating from departing members constituted a significant part of the group's work. Excercising this assimilation and accomodation capacity enabled the group to grow and change while maintaining a continuity of identity.

Table 1 about here

The third category, group cohesion, best described the movement of the group toward committment and reciprocal interaction among members. Sharing, giving and receiving in an honest, sincere manner provided the foundation for valuing the group as a viable, dependable entity.

The group repeatedly subjected itself to scrutiny to overcome impasses and promote clarification of problems. This constituted the fourth category of themes, group problem-solving. Exploring group reactions to negative affect such as silence, topic diversions, and scape-goating furthered the group's ability to discriminate and identify maladaptive responses. When confusion arose over meaning or motivation, such as distinguishing support from protection, the group increased involvement and participation in order to pool these resources for problem-solving. In this way the group learned to identify, define, and explore a range of possible solutions to problems by coordinating efforts.

Because of the constant turnover of membership, the generalization of group activities to adaptive functioning in the outside world, the fifth category, was a consistent concern. Among the principles valued and utilized by the group, communication skills, activism and participation, flexibility, self-determinism, and decision-making skills were believed to be helpful in better negotiatiing a wide range of life situations. Strong emphasis was placed on the importance of frequent practice with these skills. The group environment of support and commitment to the growth and advancement of the members was contrasted with the external environment which would be less tolerant of change and thus not conducive to maintaining personal gains from the group experience. This perspective proved especially helpful to those readmitted and returning to the group after a period of de-hospitalization.

The final category involves affect. The recognition, definition and control of affective states such as anger, fear, and sadness occupied much group interest. Acceptance and mediation of these affects was relevant to all patients, regardless of diagnosis.

DISCUSSION

Despite its instability and the relative severity of emotional distress, the group worked well at supporting functional behavior. Members established boundaries, particularly through limit setting and membership. They actively encouraged the expression of affect and appreciated it as a way of developing group cohesion. They also focused on how knowledge derived from the group could be generalized to the milieu and home. The most surprising finding was the heavy emphasis placed on problem-solving. The group equally valued problem-solving and Maxmen's "therapeutic behaviors" of working on target symptoms. Self-esteem and affect appeared to improve as a function of giving in the form of advice, insight, and empathy and its consequent effectiveness rather than on the overcoming of target symptoms. Identifying oneself as enabler appeared to be even more highly regarded by the patients than being the one most improved. The role of group members as primary therapeutic agents was very much in evi dence (see Maxmen, 1978).

Several important methodological issues were also noted during the three-month study period. The screening process we chose was essentially the same as that of Maxmen. Although the co-therapist screened and oriented each referral, we found this process redundant. The referral agents were so appropriate in their recommendations that only two of the patients were deemed inappropriate for group by co-therapists. We agree with Erickson (1981) that groups of pre-selected patients are impractical in short-stay wards.

Another interesting methodological issue was the concept of boundary. One of the co-therapist's responsibilities was reinforcing the separation of group and milieu. Attempts were often made to permeate this boundary by calling patients away during group time for assessments, medications, or adjunctive treatment. Despite an excellent working relationship between the co-therapists and milieu staff, and the perceived usefulness of this modality, the integrity of the group was continuously tested and had to be protected with vigilance.

A final methodological issue, voluntary participation, was a pseudo-issue masking more important considerations, the chief one being maximum beneficial participation. In our screening process, much time was wasted with patients discussing their voluntary status. Again, we agree with Erickson (1981) that voluntary patients in effect submit to a total treatment program. Subsequent to our study, we dropped both the screening process and discussions of voluntary participation. We accepted all referrals with minimal disruption to group census or group process.

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Table 1

MAJOR THEMES IN INPATIENT GROUP PSYCHOTHERAPY

MAJOR THEMES	THEME EXPRESSION IN GROUP	EXAMPLES
1. Boundaries	A. Limit setting	Rules for group behavior
	B. Group integrity	Confidentiality Minimize external intrusions
2. Group Composition	A. Stability	Membership changes
	B. Continuity	Permanence of group; returning members
3. Cohesion	A. Committment	"Honest" involvement
	B. Interaction	Increasing reciprocal involvement
4. Problem Solving	A. Definition	Identification of problem by exploring group reactions
	B. Solution	Active involvement by all members
5. Generalization	A. Communication skills	Participation
	B. Activism	Decision making; self-determination
6. Affect	A. Recognition	Non-verbal cues
	B. Control	Expression of affect in group; acceptance